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No. ___.

IN THE

Supreme Court of the United States

LOCAL 464A UFCW WELFARE REIMBURSEMENT PLAN,
Petitioner,

v.

PASCACK VALLEY HOSPITAL, INC.,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Do the federal courts have removal jurisdiction over a state-court lawsuit governed by federal common law, where the complaint does not identify the source of the common-law right?

PARTIES TO THE PROCEEDINGS BELOW

All parties to the proceedings in the courts below are listed in the caption.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner prays that the Court issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The decision of the District Court is unreported and is set forth at pages 24a to 25a of the Appendix (App. 24a-25a). The decision of the Court of Appeals, App. 1a-23a, is reported at 388 F.3d 393 (3d Cir. 2004).

On November 30, 2004, the Court of Appeals denied defendant-appellee's petition for rehearing *en banc*. App. 2a-3a. On December 23, 2004, the Court of Appeals recalled the mandate and filed an order amending the caption of its earlier opinion. App. 1a.

JURISDICTION

On January 31, 2005, Justice Souter granted petitioner's application for an extension of time until April 29, 2005. Case 04A664. This petition is timely under S.Ct.R. 13.5.

This Court has jurisdiction under 28 U.S.C. §1254(1), even though the Court of Appeals ordered a remand to state court. Under 28 U.S.C. §1447(d), orders of a district court remanding a case to state court for lack of federal jurisdiction are not subject to appellate review. *See, e.g., Things Remembered, Inc. v. Petrarca*, 516 U.S. 124, 127-128 (1995). In this case, however, the District Court did not remand the case to state court, but instead entered a final judgment on the merits. *See* App. 10a, 26a. This case was therefore properly "in" the Court of Appeals within the meaning of §1254(1). App. 10a. This Court, in turn, has consistently exercised *certiorari* jurisdiction under §1254(1) in cases where the district court did not order a remand but the court of appeals held that it should have. *See, e.g., City of Chicago v. Int'l College of Surgeons*, 522 U.S. 156 (1997); *Mesa v. California*, 489 U.S. 121 (1989); *Grubbs v. General Electric Credit Corp.*, 405 U.S. 699 (1972).

STATUTES INVOLVED

The federal-question jurisdiction statute, 28 U.S.C. §1331, provides:

> The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

The federal removal statute, 28 U.S.C. §1441, provides in relevant part:

> (a) Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant

> or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending. . . .
>
> (b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties.

STATEMENT OF THE CASE

A. Facts

Petitioner ("the Plan") is an employee welfare benefit plan regulated by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§1001-1461. The Plan provides reimbursement for out-of-pocket medical expenses for eligible participants employed in the retail food industry in New Jersey. App. 6a.

The Plan has a subscriber agreement with MagNet, Inc., a marketing consultant, which allows Plan members discounted rates for medical care provided by hospitals within the MagNet network. App. 6a. Under the MagNet contract, the Plan makes payment to network hospitals directly for medical services rendered to Plan participants and beneficiaries, if those persons execute assignments of their Plan benefits to the hospitals. App. 7a. If the Plan pays the claims within thirty days after they are submitted, the hospital accepts discounted rates for the medical services provided to participants. App. 7a.

Respondent Pascack Valley Hospital ("the Hospital") is a hospital in the MagNet network. App. 7a. In 1999, the Hospital treated two Plan participants, Betty Psaras and Kimberly Rovetto. App. 7a. The Hospital submitted claims for those participants' reimbursement benefits, and the Plan paid the claims at the discounted rates. App. 7a-8a. After accepting payment, the Hospital alleged that the Plan had not

paid the claims within the "discount period" of the MagNet subscriber agreement. App. 8a. The Hospital sought payment from the Plan for the difference between its full billing rates and the discounted rate. App. 8a.

B. Proceedings Below

On October 23, 2002, the Hospital filed a complaint in the Superior Court of New Jersey against the Plan. App. 8a. The Hospital's complaint alleged two common-law causes of action for unjust enrichment against the Plan, resulting from the Plan's alleged failure to pay the full balance of the claims. App. 27a-30a, First Count, ¶ 12; Second Count, ¶ 7.

The Plan removed the Hospital's complaint to the U.S. District Court for the District of New Jersey. App. 8a. On September 26, 2003, the District Court (Cavanaugh, J.) denied the Hospital's motion to remand the case to state court. App. 24a-25a. The District Court found ERISA jurisdiction over the Hospital's claims, and gave the Hospital the opportunity to refile its complaint to allege ERISA claims. App. 26a. The Hospital did not do so: it appealed the denial of its remand motion, electing to renounce any right to proceed in federal court. App. 10a.

The Third Circuit vacated the District Court's judgment and ordered remand to state court, finding no federal jurisdiction under 28 U.S.C. §1331. App. 11a-13a. The Third Circuit acknowledged Circuit precedent that there is a federal common law of ERISA applicable to claims that an ERISA Plan has unjustly retained money under a contract bearing on benefits. App. 12a, *citing Bollman Hat Co. v. Root*, 112 F.3d 113, 115 (3d Cir. 1997); *Airco Indus. Gases, Inc. Div. of the BOC Group, Inc. v. Teamsters Health & Welfare Pension Fund*, 850 F.2d 1028, 1033-34 (3d Cir. 1988); *N.E. Dep't ILGWU Health & Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 724 F.2d 147, 154-55 (3d Cir. 1985) (Becker, J., writing for himself). However,

the Third Circuit held that plaintiffs must deliberately invoke such federal common law before the federal courts may exercise removal jurisdiction. App. 12a. Because the Hospital's complaint was filed in state court, with no reference to the federal common law of ERISA, the Third Circuit held the Hospital's complaint was not removable. App. 12a. The Third Circuit held the federal character of the common law is merely a *defense* that may be raised in state court: "The Plan may be correct that, in interpreting the Subscriber Agreement, the federal common law of ERISA displaces state law. Nevertheless, potential defenses, even when anticipated in the complaint, are not relevant under the well-pleaded complaint rule." App. 12a-13a.[1]

REASONS FOR GRANTING THE WRIT

The Third Circuit's decision conflicts with decisions of this Court and several other Circuits, and raises an important question of federal law that this Court should resolve.

The Third Circuit's decision enforces that Circuit's formalistic reading of the "well-pleaded complaint" rule. This rule gives the plaintiff, not the federal court, the power to say what law underlies a common-law claim. The mere fact that a plaintiff has filed in state court will make the action unremovable, even if the action is really governed by federal common law. This approach conflicts with the decisions of this Court and most other Circuits defining when a state-law claim "arises under" federal law within the meaning of 28 U.S.C. §§1331 and 1441. This case gives this Court an opportunity to clarify this point for federal removal jurisdiction.

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[1] The Third Circuit went on in Part IV of its opinion, App. 13a-22a, to hold that plaintiff's claim is not subject to "complete preemption" under §502(a) of ERISA, 29 U.S.C. §1132(a). Petitioner does not seek certiorari as to this holding. Petitioner seeks review only of the Third Circuit's rejection of "arising under" jurisdiction under 28 U.S.C. §1331 in Part III of its opinion, App. 12a-13a.

The Third Circuit's rule is a vestige of code-pleading, abandoned in federal courts in 1938. Before 1938, federal law required plaintiffs to articulate precisely which law governs, as a condition for jurisdiction. Code-pleading has now given way to a notice-pleading regime, in which a plaintiff's pleading of facts will support federal jurisdiction even if the plaintiff does not specify the source of law.

This change has consequences for removal jurisdiction as well. Federal jurisdiction must now exist if the facts pled and relief sought actually arise under federal common law, no matter how much the plaintiff prefers a state forum.

A. The unsettled state of "arising under" jurisdiction

The problem of when a cause of action "arises under" federal law is a recurring one. Despite decisions like *Franchise Tax Board v. Const. Laborers Vacation Trust*, 463 U.S. 1, 14 (1983), and *Merrell Dow Pharmaceuticals, Inc. v. Thompson*, 478 U.S. 804, 816 (1986), commentators agree that the problem remains unsettled. "[I]t cannot be said that any clear test has yet been developed to determine which cases 'arise under' federal law. There is no single rationalizing principle that will explain all of the decisions on this point. The problem has been aggravated by the tendency of courts to repeat uncritically language from earlier decisions as a substitute for analysis of the case that is actually before them." Wright, Miller and Cooper, 13B *Federal Practice and Procedure*, Juris.2d §3562 (2005). *See also* Fuller, *Federal Question Jurisdiction*, Loy. L.A. L.Rev. 1443, 1444 (2004); Note, *Mr. Smith Goes to Federal Court: Federal Question Jurisdiction Over State Law Claims Post-Merrell Dow*, 115 Harv. L.Rev. 2272, 2282 (2002).

The problem is connected to the "well-pleaded complaint" doctrine associated with *Louisville & Nashville RR Co. v. Mottley*, 211 U.S. 149 (1908), and *Gully v. First National Bank*, 299 U.S. 109 (1936). Under this doctrine, the plaintiff

has the power to frame its pleadings, and its decision not to invoke a federal claim must be honored. "The party who brings a suit is master to decide what law he will rely upon and therefore does determine whether he will bring a 'suit arising under' . . . the law of the United States." *Fair v. Kohler Die & Specialty Co.*, 228 U.S. 22, 25 (1913).

Taken to its logical conclusion, this "master of the complaint" rule would make removal impossible whenever the plaintiff does not expressly acknowledge the federal nature of its claim. Yet in recent years, this Court has held that a state-court action may be removable over the plaintiff's objection when "it appears that some substantial, disputed question of federal law is a necessary element of one of the well-pleaded state claims, or that one or the other claim is 'really' one of federal law." *Franchise Tax Board*, 463 U.S. at 13; *City of Chicago v. Int'l College of Surgeons*, 522 U.S. 156, 164 (1997).

These opposing doctrines are not easily reconciled. *See* Miller, *Artful Pleading: A Doctrine In Search of a Definition*, 76 Tex. L.Rev. 1781, 1789 (1998). Courts must now decide when they must defer to a plaintiff's legal conclusion, and when courts may decide for themselves the federal nature of a claim, over the plaintiff's objection.

The problem is particularly acute when a plaintiff seeks relief under the common law, rather than a state statute. Unlike a statutory claim, a common-law claim typically does not identify the particular authority that created it. As in this case, App. 27a-29a, a common-law claim simply recites a grievance, pleads supporting facts, and asks the courts for relief. Such a complaint invokes judge-made law, without naming the judges or legal system that creates that law. *See* Bellia, *State Courts and the Making of Federal Common Law*, 153 U. Pa. L.Rev. 825, 840 (2005). The problem is whether the federal courts must defer to the plaintiff's view of which legal system has created this law.

B. The Third Circuit's formalistic reading of the "well-pleaded complaint" rule

In this case, plaintiff's complaint did not invoke any State legislation or statutory remedies. App. 27a-30a. The complaint alleged that the defendant, an employee benefits plan, had wrongfully retained money due the plaintiff hospital under the terms of a contract bearing on reimbursement benefits. Plaintiff claims the Plan has been unjustly enriched, and seeks relief. App. 29a-30a.

In this case, the Third Circuit recognized that there is a federal common law of ERISA[2] that governs claims that an ERISA Plan has unjustly retained money under a contract bearing on benefits. App. 12a, *citing Bollman Hat Co. v. Root*, 112 F.3d 113, 115 (3d Cir. 1997); *Airco Indus. Gases, Inc. Div. of the BOC Group, Inc. v. Teamsters Health & Welfare Pension Fund*, 850 F.2d 1028, 1033-34 (3d Cir. 1988); *N.E. Dep't ILGWU Health & Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 724 F.2d 147, 154-55 (3d Cir. 1985) (Becker, J., writing for himself). *See also McGurl v. Trucking Employees of New Jersey Welfare*

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[2] A majority of other circuits also recognize a federal common-law right arising under ERISA. *State Street Bank & Trust Co. v. Denman Tire Corp.*, 240 F.3d 83, 88 (1st Cir. 2001); *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985, 988 (4th Cir. 1990); *Whitworth Bros. Storage Co. v. Central States Pension Fund*, 794 F.2d 221, 235 (6th Cir. 1986); *but see Cooperative Benefit Administrators v. Ogden*, 367 F.3d 323, 328 (5th Cir. 2004); *Pacificare, Inc. v. Martin*, 34 F.3d 834, 836 (9th Cir. 1994).

This federal common-law action is independent of the equitable enforcement mechanism of §502 of ERISA, 29 U.S.C. §1132. *See N.E. Dep't ILGWU*, 724 F.2d at 156. A federal common-law action remains viable under ERISA even after *Great-West Life Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002), because the action is not created by the statutory limitations of §502 of ERISA. *See Empire Kosher Poultry, Inc. v. UFCW Health and Welfare Fund*, 285 F.Supp.2d 573, 579-582 (M.D.Pa. 2003) (federal-common-law remedies in Third Circuit are not limited by *Knudson*).

Fund, 124 F.3d 471, 476 (3d Cir. 1997) (suit between overlapping funds over which was liable for participant's care); *Plucinski v. IAM Nat'l Pension Fund*, 875 F.2d 1052, 1057-58 (3d Cir. 1989) (employer suit for unjust enrichment). Each of these cases involved disputes, like this one, between an ERISA Plan and a third party over the Plan's retention of money allegedly due under a contract bearing on Plan benefits. In *Plucinski* and *Airco*, the common-law claim was styled in the identical form as plaintiff's claim here—for unjust enrichment. The only difference between those cases and the present one is that the plaintiffs in *Plucinski* and *Airco* invoked federal jurisdiction by acknowledging the federal nature of their common-law claims.

The Third Circuit rejected federal jurisdiction, not because the plaintiff's pleading could not have been filed in federal court, but solely because the plaintiff did not explicitly invoke ERISA or its federal common law. App. 12a. The Third Circuit analyzed the state-court action as though the plaintiff brought a claim completely separate from federal law. In the Third Circuit's view, the federal courts are powerless to correct the plaintiff's legal conclusion that federal law does not govern.[3]

The Third Circuit's approach reflects the most rigid reading of the "well-pleaded complaint" rule in the Circuits. Removal here was not based on a federal *defense*. Federal common law does not extinguish the Hospital's claim—it is its legal source. Yet the Third Circuit held that the plaintiff's

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[3] The Third Circuit had earlier applied similar reasoning in rejecting removal of common-law claims in *Goepel v. Nat'l Postal Mail Handlers Benefit Plan*, 36 F.3d 306, 314-315 (1994) *cert. denied*, 514 U.S. 1063 (1995), and *Allstate Insurance Co. v. The 65 Security Plan*, 879 F.2d 90, 93-94 (3d Cir. 1989). In *Goepel* and *Allstate*, the Third Circuit rejected the argument that federal common law could authorize the removal of a state cause of action, where the plaintiff did not acknowledge the application of federal law to the complaint.

characterization of the claim as a creature of state law, however erroneous, precluded removal. According to the Third Circuit, a court could only correct the plaintiff's error by adjudicating a defense, not by declaring the true legal source of plaintiff's common-law claim. App. 12a-13a.

The strange result of the Third Circuit's rule is that a complaint that might have been *filed* in federal court may not be *removed* there. The plaintiff could have filed the identical unjust-enrichment action in federal court, with the same factual allegations and common-law claims. Even though the plaintiff did not identify ERISA or federal common law, the federal court could have entertained it under 28 U.S.C. §1331. *See Schlesinger v. Councilman*, 420 U.S. 738, 742 & n.5 (1975) (complaint's failure to specify basis for jurisdiction not fatal: "we think that so long as the court's subject matter jurisdiction actually existed . . . any defect in the manner in which the action was instituted and processed is not itself jurisdictional . . ."). Yet in the Third Circuit's view, the plaintiff's mere decision to file a common-law claim in state court is an implicit declaration, however erroneous, that federal law does not apply.

The Third Circuit's decision is contrary to this Court's explanation in *City of Chicago v. Int'l College of Surgeons*, 522 U.S. 156, 164 (1997), that a case is removable if it could have been brought in federal court in the first instance. In *City of Chicago*, a property owner framed a state-law cause of action that in essence asserted federal constitutional rights against the City. The City removed, but the Seventh Circuit ordered the case remanded to state court, on the ground that as master of the complaint, the property owner had a right to style its action under state law. This Court reversed and upheld the removal. It acknowledged that the federal claims "were raised by way of a cause of action created by state law." 522 U.S. at 164. But it reaffirmed that "even though state law creates [a party's] cause of action, its case might

still 'arise under' the laws of the United States if a well-pleaded complaint established that its right to relief under state law requires resolution of a substantial question of federal law." *Id.*, *quoting Franchise Tax Board*, 463 U.S. at 13. The Court concluded that because the property owner's use of state law to enforce federal constitutional rights "arose under" federal law, removal was proper: "Accordingly, [the property owner] errs in relying on the established principle that the plaintiff, as master of the complaint, can 'choose to have the cause heard in state court.' [cit.om.] By raising several claims that arise under federal law, [the property owner] subjected itself to the possibility that the City would remove the case to the federal courts." *City of Chicago*, 522 U.S. at 164.

This "arising under" removal jurisdiction in *City of Chicago* was not predicated on complete preemption. The federal claims at issue there (takings claims under the Fifth and Fourteenth Amendments) were not part of any complete-preemption exception. Yet if a state-law cause of action "arises under" federal law, it is removable even if the plaintiff does not acknowledge it, and even if the federal law does not completely preempt state law. This Court now treats removal jurisdiction as coextensive with the power of a federal court to hear the case if it had been brought in federal court in the first instance. *Wisconsin Dep't of Corrections v. Schacht*, 524 U.S. 381, 390 (1998) ("Since a federal court would have original jurisdiction to hear this case had [the plaintiff] originally filed it there, the defendants may remove the case from state to federal courts.").

C. The Third Circuit's rule is a vestige of code-pleading.

The Third Circuit's decision is not an isolated failure to follow this Court's direction. It reflects an unconscious hold-over from the era of code pleading. The Court should take this case to clarify and correct this persistent error.

Judge Easterbrook has explained why the continued adherence to code pleading has complicated federal jurisdiction. In *Int'l Armor & Limousine Co. v. Moloney Coachbuilders, Inc.*, 272 F.3d 912, 915 (7th Cir. 2001) *cert. denied*, 535 U.S. 1078 (2002), and *Bartholet v. Reishaeur A.G.*, 953 F.2d 1073, 1078 (7th Cir. 1992), Judge Easterbrook noted that the seminal cases defining the "well-pleaded complaint" rule (like *Gully* and *Mottley*) were decided under the pre-1938 regime of code pleading. This system required the plaintiff to specify the legal theory on which the action was based: "Common law pleading required the advocate to match facts to a legal theory . . . Code pleading ended up in much the same place, as courts read the code formula 'facts constituting a cause of action' to require the pleader to state a legal theory." *Bartholet*, 953 F.2d at 1078. After the 1938 change to notice pleading, the plaintiff's declaration of its legal theory is no longer essential to jurisdiction: "[U]nder the Federal Rules of Civil Procedure the concept of "cause of action" as Holmes used it—a reference to a code-pleading regime in which law was essential to the plaintiff's complaint—has vanished from federal law and been replaced by notice pleading, which need not specify a source of law." *Moloney Coachbuilders*, 272 F.3d at 915.

This change from code pleading to notice pleading gives courts, rather than plaintiffs, the power to define the law governing a claim. "Under the Federal Rules, courts rather than parties decide which rules of law govern the disputes . . . Although the well-pleaded complaint doctrine of *Gully* [cit om.] establishes that the federal element must be part of the plaintiff's claim (as opposed to a defense), it does not mean that the plaintiff may maneuver a case into or out of federal court at will by including or omitting federal aspects. In our notice-pleading regime (adopted two years after *Gully*) the district court looks past surface allegations to make its own assessment of what law the claim arises under." *Moloney Coachbuilders*, 272 F.3d at 915.

This Court should adopt Judge Easterbrook's analysis. The Third Circuit's absolutist approach to the "well-pleaded complaint" rule reflects the assumptions of the code-pleading era, in which the plaintiff's articulation of a legal theory was decisive for jurisdiction. After the demise of code pleading, the plaintiff's allegation of facts, and claim for common-law relief, is enough to support federal jurisdiction. The federal courts need no longer defer to a litigant's erroneous characterization of the law governing a common-law complaint.

D. The Third Circuit's rule is in conflict with several other Circuits, affecting many areas of federal law.

The Third Circuit decision here is not an isolated error. The Third Circuit earlier applied similar reasoning in rejecting removal of common-law claims in *Goepel v. Nat'l Postal Mail Handlers Benefit Plan*, 36 F.3d 306, 314-315 (3d. Cir. 1994) *cert. denied*, 514 U.S. 1063 (1995) (3d. Cir. 1994) and *Allstate Insurance Co. v. The 65 Security Plan*, 879 F.2d 90, 93-94 (3d Cir. 1989). In *Goepel* and *Allstate*, the Third Circuit rejected the argument that federal common law could authorize the removal of a state cause of action, where the plaintiff did not acknowledge the application of federal law to the complaint.

The Third Circuit recognized in *Goepel* that its approach to "arising under" jurisdiction conflicts with other Circuits'. *Goepel*, 36 F.3d at 313-315, went to great lengths to criticize the Fourth Circuit's contrary approach in *Caudill v. Blue Cross and Blue Shield*, 999 F.2d 74, 77 (4th Cir. 1993). The conflict between the Third and the Fourth Circuit is especially sharp here. The Fourth Circuit (in direct contrast to this decision) holds that a state-court common-law action that does not specify the source of law is removable if the federal court concludes that the law is federal. *Battle v. Seibels Bruce Ins. Co.*, 288 F.3d 596, 607 (4th Cir. 2002) ("Battle's

complaint does not specify upon what law, state or federal, he premises either of these claims. Accordingly, we cannot conclude that Battle's complaint establishes that federal law creates either claim. However, we do conclude that Battle's complaint establishes that Battle's right to relief under either claim 'necessarily depends on resolution of a substantial question of federal law.' [cit. om.] . . . [T]he law is well settled that federal common law alone governs the interpretation of insurance policies issued pursuant to the NFIP.")

This problem occurs in many areas of federal law where there is no recognized "complete preemption," but where actions brought in state court arise under federal common law. In addition to the contrary law in the Fourth and Seventh Circuits, several other Circuits' resolution of state-law claims conflict with the Third Circuit's approach.

As to state-law claims that implicate the federal "filed rate" doctrine, the Second, Ninth and Eleventh Circuit have allowed "arising under" removal over state-court actions that the courts judged were actually challenges to the federal tariffs. *Marcus v. A T & T Corp.*, 138 F.3d 46, 55-56 (2d Cir. 1998) (state-court action for breach of warranty removable because it challenges tariffs filed with the FCC: "A complaint which appears to be grounded solely in state law actually may be federal in nature, and thus removable, if its true nature has been disguised by the plaintiff's artful pleading."), *California ex rel. Lockyer v. Dynegy, Inc.*, 375 F.3d 831, 837 (9th Cir. 2004) ("the rule that state law claims cannot be alchemized into federal causes of action by incidental reference . . . has no application when relief is partially predicated on a subject matter committed exclusively to federal jurisdiction"), *cert. denied*, ___ U.S. ___, 73 USLW 3466 (2005); *Hill v. BellSouth Telecommunications, Inc.*, 364 F.3d 1308, 1314-15 (11th Cir. 2004) (although plaintiff is the master of the complaint, state-law claims attacking the application of an FCC-filed tariff were removable because they raised federal questions).

The Second and Ninth Circuits permit removal of state-law actions as "arising under" the securities laws where the court concludes they allege violations of federal securities laws. *D'Alessio v. New York Stock Exchange*, 258 F.3d 93, 99-103 (2d Cir.) (plaintiff pleads common-law claims under New York law, but the case is removable because the claims allege violations of federal securities regulations) *cert. denied*, 534 U.S. 1066 (2001); *Sparta Surgical Corp. v. Nat'l Ass'n of Securities Dealers*, 159 F.3d 1209, 1212-12 (9th Cir. 1998) (plaintiff pleads common-law claims under California law, but case is removable because the claims allege violations of federal securities regulations: "A plaintiff may not avoid federal jurisdiction by omitting from the complaint federal law essential to his or her claim or by casting in state law terms a claim that can be made only under federal law.").

If the Third Circuit's approach were correct, none of these claims could have been removed to federal court. The plaintiff's choice to ignore the federal basis of the common-law claim would have been enough to defeat removal.

The doctrines of the "well-pleaded complaint" and the bar against "artful pleading" should have consistent application. They should not be mere slogans to justify removal or remand at the court's discretion. This Court should grant certiorari to clarify this unsettled issue in federal jurisdiction.

CONCLUSION

The Court should grant the petition for certiorari.

Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Case No: 03-4196

PASCACK VALLEY HOSPITAL, INC.;
Appellant,

v.

LOCAL 464A UFCW WELFARE REIMBURSEMENT PLAN

On Appeal From The United States District Court
For The District Of New Jersey
(Civ. A. No. 02-CV-05974)

District Judge: The Honorable Dennis M. Cavanaugh

Before: ALITO, SMITH, and WALLACE, *Circuit Judges*[*]

ORDER

The captions in the Opinion and the Judgment in this case, which were filed November 1, 2004, are hereby amended to eliminate any reference to Community Medical Center, Lawrence Taylor, and Debra Saverino. The caption in this Order is correct. The Clerk is directed to issue an amended mandate.

By the Court,

/s/ D. Brooks Smith
Circuit Judge

DATED: 23 December 2004

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[*] The Honorable J. Clifford Wallace, Senior Circuit Judge for the United States Court of Appeals for the Ninth Circuit, sitting by designation

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 03-4196

PASCACK VALLEY HOSPITAL, INC.;
COMMUNITY MEDICAL CENTER,
(LAWRENCE TAYLOR, DEBRA SAVERINO)

v.

LOCAL 464A, UFCW WELFARE REIMBURSEMENT PLAN,
Pascack Valley Hospital, Inc.,
Appellant.

SUR PETITION FOR REHEARING

Present: SCIRICA, *Chief Judge*, SLOVITER, NYGAARD, ALITO, ROTH, McKEE, RENDELL, BARRY, AMBRO, FUENTES, SMITH, CHERTOFF, FISHER, VAN ANTWERPEN and WALLACE, *Circuit Judges.*[*]

The petition for rehearing filed by appellant in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular service not having voted for rehearing, the petition for rehearing by the panel and the Court en banc, is denied.

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[*] The vote of the Honorable J. Clifford Wallace, Senior United States Circuit Judge for the Ninth Circuit, who sat by designation, is limited to panel rehearing.

BY THE COURT,

/s/ D. Brooks Smith
Circuit Judge

Dated: 30 November 2004

APPENDIX C

PRECEDENTIAL

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

[Filed November 1, 2004]

No. 03-4196

PASCACK VALLEY HOSPITAL, INC.;

v.

LOCAL 464A UFCW WELFARE REIMBURSEMENT PLAN,
Pascack Valley Hospital, Inc.,
Appellant.

On Appeal From The United States
District Court For The District Of New Jersey
(D.C. Civil No. 02-cv-05974)

District Judge: The Honorable Dennis M. Cavanaugh

Argued June 16, 2004

Before: ALITO, SMITH, and WALLACE, *Circuit Judges* *

SHEA H. LUKACSKO
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* The Honorable J. Clifford Wallace, Senior Circuit Judge for the United States Court of Appeals for the Ninth Circuit, sitting by designation.

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AMENDED OPINION

SMITH, *Circuit Judge*.

This case presents a question of jurisdiction under the civil enforcement provision of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a). Pascack Valley Hospital (the "Hospital") sued the United Food and Commercial Workers International Union Local 464A, AFL-CIO Group Reimbursement Welfare Plan (the "Plan") in state court for breach of contract. The Plan removed the case to federal district court and moved for summary judgment. The Hospital moved to remand. The District Court held that the Hospital's breach of contract claims against the Plan were completely pre-empted by ERISA and therefore raised a federal question supporting removal under 28 U.S.C.

§ 1441(a). We hold that, under the well-pleaded complaint rule, the Hospital's complaint does not present a federal question that would support removal. We further hold that the Hospital's state law breach of contract claims are not completely pre-empted by ERISA's civil enforcement provision because the Hospital could not have brought its claims under ERISA. We will therefore vacate the judgment of the District Court and remand to that court with instructions that it, in turn, remand these proceedings to the state court whence they came.

I.

The Plan is an "employee welfare benefit plan" as defined by ERISA. 29 U.S.C. § 1002(1).[1] The Plan is a reimbursement plan only; it reimburses participants and beneficiaries for out-of-pocket medical expenses but does not itself provide medical care.

MagNet, Inc. is an independent consultant. MagNet has organized a network of hospitals that have agreed to accept discounted payment for medical services provided to beneficiaries of group health plans in return for the plans' promise to encourage beneficiaries to use network hospitals. Network hospitals do not contract directly with the plans. Instead, MagNet enters into separate contracts with individual plans, and separate contracts with individual hospitals.

Around 1995, the Plan entered into a "Subscriber Agreement" with MagNet. In 1996, the Hospital entered into a "Network Hospital Agreement" with MagNet. Section 2.1 of

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[1] An ERISA Plan is a legal entity that can sue and be sued. 29 U.S.C. § 1132(d)(1). Accordingly, the term "Plan" refers not only to the defendant in the underlying lawsuit and the appellee before this Court, but also to the underlying "[r]ules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services" that make up an employee welfare plan. *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000).

the Subscriber Agreement governs "Hospital payment," and provides that the discounted rate offered by the Hospital will be forfeited unless claims are timely paid:

> Subscriber . . . shall pay Network Hospitals for Covered Services furnished to Eligible Persons.
>
> Pursuant to a valid assignment from Eligible Person, Subscriber . . . shall directly pay Network Hospitals for Covered Services provided to Eligible Persons within thirty (30) days after date of receipt of submitted Clean Claims. . . .
>
> For other non-clean claims, payment shall be made within thirty (30) days of receipt of all records and other information necessary for proper claims adjudication.
>
> . . .
>
> Where obligated, if Subscriber fails to pay within the appropriate time frame, the Subscriber acknowledges that it will lose the benefit of the MagNet discounted reimbursement rate and that Network Hospital is then entitled to bill and collect from Subscriber and Eligible Person its customary rate for services rendered. If Subscriber fails to make the payment, the Network Hospital may pursue any remedies available against Subscriber and Eligible Person.

In 1999, the Hospital provided medical services to Kimberly Rovetto and Betty Psaras. Both Psaras and Rovetto were "Eligible Persons" under the Subscriber Agreement, and the medical services provided to Psaras and Rovetto were "Covered Services" under the Subscriber Agreement. The Hospital alleges that the Plan failed to pay the Hospital for the services rendered to Psaras and Rovetto according to the terms of the Subscriber Agreement. The Hospital contends that claims for those services were properly submitted on April 15, 1999, and October 5, 1999. The Hospital further

contends that it received payment on these claims at the discounted rate on June 8, 1999, and November 22, 1999, respectively. According to the Hospital's interpretation of § 2.1 of the Subscriber Agreement, the Plan's failure to pay these claims within thirty days of receipt effected a forfeiture of the discounted rate provided in the Network Hospital Agreement. The Hospital therefore seeks to recover the allegedly forfeited discount from the Plan.

On October 23, 2002, the Hospital filed suit in the Superior Court of New Jersey.

The Complaint alleges that the Hospital is a third-party beneficiary to the Subscriber Agreement between MagNet and the Plan, under which the Plan "became obligated to pay [the Hospital] for eligible medical services provided by [the Hospital]," and "was required to comply with certain terms and conditions of [the Hospital's] contract with MagNet [i.e., the Network Hospital Agreement], requiring payment in the time period specified in said contract." The two-count complaint alleges that the Plan breached this contract by improperly taking a discount on the services provided to Psaras and Rovetto despite the Plan's failure to make timely payment under the Subscriber Agreement.[2]

The Plan removed the case to the District Court. Thereafter, the Plan moved for summary judgment and the Hospital cross-moved to remand the case to state court. The parties' motions focused on whether, under the doctrine of "complete pre-emption," the Hospital's state law breach of contract claims raised a federal question. The District Court heard oral argument on the parties' motions on September 25, 2003. The

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[2] The Plan incorrectly states that "[t]he Hospital's complaint only claims *unjust enrichment*." Appellee's Br. at 2, 21-22. Although the Complaint does allege that the Plan "has been unjustly enriched to the detriment of [the Hospital]," the Complaint explicitly alleges that the Plan "breached" its contractual obligations to the Hospital.

next day, on September 26, 2003, the District Court issued an Opinion and Order granting the Plan's motion for summary judgment, denying the Hospital's cross-motion to remand, and dismissing the complaint without prejudice. The District Court's two-page Opinion and Order states in relevant part:

> Defendant believing that Plaintiff's state law claims are completely preempted by [ERISA] in that Plaintiff now stands in the shoes of the Plan's beneficiaries as assignee, AND THEREFORE Defendant believes the facts show it is entitled to judgment as a matter of law; and
>
> Plaintiff believing the action is not preempted by ERISA since Plaintiff is not a participant or beneficiary under ERISA and therefore there is no federal law claim, and therefore the matter should be remanded to the state court; and
>
> This Court being in agreement with and adopts the reasoning of counsel for Defendant as stated on the record, and further rejects the arguments put forth by counsel for Plaintiff; and
>
> This Court agrees with and adopts the analysis and holding as set forth in *Charter Fairmount Institute, Inc. v. Alta Health Strategies*, 835 F. Supp. 233; and
>
> This Court being satisfied that [the doctrine of complete preemption] having been met in this case; and
>
> As this case falls within the "complete preemption" exception to the well pleaded complaint doctrine, removal to federal court was proper, and remand to state court would be inappropriate . . . .

(Footnote omitted). The Hospital filed a timely notice of appeal on October 22, 2003.

II.

Before turning to the District Court's removal jurisdiction, we must first address our own appellate jurisdiction. Although the District Court purported to grant summary judgment in favor of the Plan, the District Court actually dismissed the Hospital's complaint without prejudice. That disposition allowed the Hospital, which emphatically disavows an ERISA claim for benefits, to replead its complaint under ERISA's civil enforcement provision. The Hospital declined to do so and instead filed this appeal.

28 U.S.C. § 1291 provides this Court with jurisdiction over a final order dismissing a complaint as completely preempted. *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 445 (3d Cir. 2003). "Generally, an order which dismisses a complaint without prejudice is neither final nor appealable because the deficiency may be corrected by the plaintiff without affecting the cause of action." *Borelli v. City of Reading*, 532 F.2d 950, 951(3d Cir. 1976) (per curiam).[3] If the plaintiff elects to stand on the dismissed complaint, however, the order of dismissal is final and appealable. *Id.* at 951-52. At oral argument, counsel for the Hospital declared the Hospital's intention to forego any ERISA claim it may have and to stand on its complaint. Counsel's declaration is sufficient to render the District Court's order final and appealable. *Remick v. Manfredy*, 238 F.3d 248, 254 (3d Cir. 2001). This Court exercises plenary review over a district court's exercise of jurisdiction and order of dismissal. *DiFelice*, 346 F.3d at 445; *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 268 (3d Cir. 2001).

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[3] That the District Court also denied the Hospital's motion to remand does not make the court's order appealable. *Caterpillar Inc. v. Lewis*, 519 U.S. 61, 74 (1996) ("An order denying a motion to remand, 'standing alone,' is '[o]bviously . . . not final and [immediately] appealable' as of right." (quoting *Chicago, R.I. & P.R. Co. v. Stude*, 346 U.S. 574, 578 (1954)).

III.

A civil action filed in a state court may be removed to federal court if the claim is one "arising under" federal law. 28 U.S.C. §§ 1331, 1441(a). Under the "well-pleaded complaint" rule, the plaintiff is ordinarily entitled to remain in state court so long as its complaint does not, on its face, affirmatively allege a federal claim. *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 6 (2003). To support removal, "[a] right or immunity created by the Constitution or laws of the United States must be an element, and an essential one, of the plaintiff's cause of action.'" *Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 10-11 (1983) (quoting *Gully v. First Nat'l Bank in Meridian*, 299 U.S. 109,112 (1936)). Federal pre-emption is ordinarily a defense to a plaintiff's suit and, as such, does not appear on the face of a well-pleaded complaint. *Anderson*, 539 U.S. at 6; *Franchise Tax Bd.*, 463 U.S. at 12.

On its face, the Hospital's complaint does not present a federal question. Rather, the complaint asserts state common law claims for breach of contract. The complaint does not expressly refer to ERISA and the rights or immunities created under ERISA are not elements, let alone essential elements, of the plaintiffs claims. The possibility—or even likelihood—that ERISA's pre-emption provision, 29 U.S.C. § 1144(a), may pre-empt the Hospital's state law claims is not a sufficient basis for removal. *Franchise Tax Bd.*, 463 U.S. at 12.[4]

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[4] Pre-emption under § 514(a) of ERISA, 29 U.S.C. § 1144(a), must be distinguished from *complete* pre-emption under § 502(a) of ERISA, 29 U.S.C. § 1132(a). Only the latter permits removal of what would otherwise be a state law claim under the well-pleaded complaint rule. Under § 514(a), ERISA supersedes state laws that "relate to" an ERISA plan. 29 U.S.C. § 1144(a). Unlike the scope of § 502(a), which is jurisdictional and creates a basis for removal to federal court, § 514(a) merely governs the law that will apply to state law claims, regardless of whether the case is brought in state or federal court. *Lazorko v. Pa. Hosp.*, 237 F.3d 242, 248

The Plan argues that the Hospital's claims arise under "the federal common law" of ERISA. On several occasions, we have predicated jurisdiction on a plaintiff's invocation of the federal common law of ERISA. *Bollman Hat Co. v. Root*, 112 F.3d 113, 115 (3d Cir. 1997); *Airco Indus. Gases, Inc. Div. of the BOC Group, Inc. v. Teamsters Health & Welfare Pension Fund*, 850 F.2d 1028, 1033-34 (3d Cir. 1988); *N.E. Dep't ILGWU Health & Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147, 154-55 (3d Cir. 1985) (Becker, J., writing for himself). These cases, however, do not support the Plan's argument that removal is proper because "suits between plans and third parties implicating benefits administration 'arise under' ERISA's federal common law." Appellee's Br. at 54. Instead, the plaintiffs in these cases deliberately invoked federal ERISA jurisdiction. *See Bollman Hat*, 112 F.3d at 115 (lawsuit seeking to enforce subrogation provision in ERISA plan); *Airco*, 850 F.2d at 1031 (amended complaint asserting cause of action for unjust enrichment under ERISA); *ILGWU*, 764 F.2d at 150, 154-55 (lawsuit seeking declaratory relief regarding the meaning of terms in an ERISA plan). As such, their well-pleaded complaints necessarily arose under federal law. Here, the Hospital's complaint asserts a state law claim for breach of contract, and the federal common law of ERISA does not provide an element—essential or otherwise—of such a claim. The Plan may be correct that, in interpreting the Subscriber Agreement, the federal common law of ERISA displaces state

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(3d Cir. 2000). Section 514(a), therefore, does not permit removal of an otherwise well-pleaded complaint asserting only state law claims. *Pryzbowski*, 245 F.3d at 275 ("[W]hen the doctrine of complete preemption does not apply, but the plaintiff's state claim is arguably preempted under § 514(a), the district court, being without removal jurisdiction, cannot resolve the dispute regarding preemption." (internal quotation omitted)).

law. Nevertheless, potential defenses, even when anticipated in the complaint, are not relevant under the well-pleaded complaint rule. *Franchise Tax Bd.*, 463 U.S. at 10-12.

IV.

Although the well-pleaded complaint rule would ordinarily bar the removal of an action to federal court where federal jurisdiction is not presented on the face of the plaintiff's complaint, the action may be removed if it falls within the narrow class of cases to which the doctrine of "complete pre-emption" applies. *Aetna Health Inc. v. Davila*, 542 U.S., No. 02-1845, slip op. at 5 (June 21, 2004); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987). As a "corollary of the well-pleaded complaint rule," complete pre-emption recognizes "that Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Taylor*, 481 U.S. at 63-64; *accord Anderson*, 539 U.S. at 8 ("When the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law.").

ERISA's civil enforcement mechanism, § 502(a), "is one of those provisions with such 'extraordinary pre-emptive power' that it 'converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.'" *Davila*, slip op. at 7 (quoting *Taylor*, 481 U.S. at 65-66). As a result, state law causes of action that are "within the scope of . . . § 502(a)" are completely pre-empted and therefore removable to federal court. *Taylor*, 481 U.S. at 66; *DiFelice*, 346 F.3d at 446. The Supreme Court has recently clarified the inquiry in such cases:

> It follows that if an individual brings suit complaining of a denial of coverage for medical care, where the indi-

> vidual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls within the scope of ERISA § 502(a)(1)(B). In other words, if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B).

Davila, slip op. at 8 (internal quotation and citation omitted).

Accordingly, this case is removable only if (1) the Hospital could have brought its breach of contract claim under § 502(a), and (2) no other legal duty supports the Hospital's claim. *Id.* "[A] federal court may look beyond the face of the complaint to determine whether a plaintiff has artfully pleaded his suit so as to couch a federal claim in terms of state law." *Pryzbowski*, 245 F.3d at 274 (internal quotation omitted).

A.

We conclude that the Hospital could not have brought its claims under § 502(a) because the Hospital does not have standing to sue under that statute. Section 502(a) of ERISA allows "a participant or beneficiary" to bring a civil action, *inter alia*, "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).[5] By its terms, standing

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[5] Section 502(a) provides other causes of action not relevant on this appeal. The Plan makes no argument that the Hospital could have brought this action under any other provision of § 502(a).

under the statute is limited to participants and beneficiaries.[6] *Franchise Tax Bd.*, 463 U.S. at 27 ("ERISA carefully enumerates the parties entitled to seek relief under § 502 . . . ."). The parties agree that the Hospital is nether [sic] a participant nor a beneficiary, and that the Hospital does not have standing under ERISA to sue in its own right.

The parties dispute whether, under the law of this Circuit, the Hospital can obtain standing under § 502(a) by virtue of an assignment of a claim from a participant or beneficiary.[7]

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[6] A participant is defined as

> any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1002(7). A beneficiary is "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." *Id.* § 1002(8).

[7] In particular, the parties disagree over whether this Court's opinion in *ILGWU* forecloses derivative standing under § 502(a). Though the *ILGWU* Court denied the claimant's plan federal question jurisdiction to sue to recoup paid medical benefits from a second plan, 764 F.2d at 153, part of the Court's rationale was that the claimant had not, in fact, assigned her claim to her plan. *Id.* at 154 n.6. Therefore, while the *ILGWU* Court expressed "serious doubts whether [the claimant] could assign along with her substantive rights her right to sue in federal court," *id.*, the Court could not so hold.

District courts in this Circuit have disagreed over the scope of *ILGWU*. *Compare Allergy Diagnostics Lab. v. The Equitable*, 785 F. Supp. 523, 526-27 & n.3 (W.D. Pa. 1991) (citing Footnote 6 of *ILGWU* for the proposition that assignees of beneficiaries do not have standing to sue under § 502(a)), *and Health Scan, Ltd. v. Travelers Ins. Co.*, 725 F. Supp. 268, 269-70 (E.D. Pa. 1989) (same), *with Commonwealth of Pa. Dept of Public Welfare v. Quaker Med. Care & Survivors Plan*, 836 F. Supp. 314, 317 (W.D. Pa. 1993) (observing that given the facts of *ILGWU*, Footnote 6 is non-binding dicta in cases involving an actual assignment), *and*

We need not resolve this dispute, however, because there is nothing in the record indicating that Psaras and Rovetto did, in fact, assign any claims to the Hospital.

As the party seeking removal, the Plan bore the burden of proving that the Hospital's claim is an ERISA claim. *DiFelice*, 346 F.3d at 452. Accordingly, the Plan bore the burden of establishing the existence of an assignment. *Hobbs v. Blue Cross Blue Shield of Ala.*, 276 F.3d 1236, 1242 (11th Cir. 2001). The Plan concedes that the record contains no evidence of an express assignment, whether oral or written, from either Psaras or Rovetto to the Hospital. Instead, the Plan argues that "[t]he MagNet contract itself establishes the Hospital's claim as an assignment from the participant." Appellee's Br. at 25. Essentially, the Plan argues that (1) under the Subscriber Agreement, "[the Hospital's] only right to demand money from the Plan comes from the participant's assignment of her right to reimbursement," Appellee's Br. at 16, 24; (2) therefore, the Hospital must be suing on an assignment from Psaras and Rovetto.

The Plan's argument is a *non sequitur*. Whether the Subscriber Agreement requires the Hospital to obtain an assignment in order to demand payment from the Plan says nothing about whether an assignment was in fact made. Because neither Psaras nor Rovetto are parties to the Subscriber Agreement, that document cannot, in and of itself, establish an assignment of their claims. At best, the Plan's interpretation of the Subscriber Agreement provides an

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Charter Fairmount Inst., Inc. v. Alta Health Strategies, 835 F. Supp. 233, 238 (E.D. Pa. 1993) (same).

Almost every circuit to have considered the question has held that a health care provider can assert a claim under § 502(a) where a beneficiary or participant has assigned to the provider that individual's right to benefits under the plan, *see e..g.*, [sic] *Tango Transport v. Healthcare Fin. Servs.*, 322 F.3d 888, 891 (5th. Cir. 2003) (collecting cases), but as the issue is not squarely before us, we express no opinion on it.

affirmative defense to the Hospital's breach of contract claims, *i.e.*, that the Plan has no contractual liability absent a valid assignment. The Plan's argument may therefore entitle it to judgment on the Hospital's breach of contract claims in a court of competent jurisdiction. It does not, however, convert those breach of contract claims into derivative claims for benefits under § 502(a).[8]

Nor can we find an actual assignment based on any other documents in the record.

Section 5 of the Summary Plan Description, entitled "How Benefits Will Be Paid," provides: "If you qualify for hospital care and are entitled to reimbursement, *and the hospital has sent in an assignment executed by you*, we will pay the hospital directly . . . ." Thus, the Plan itself contemplates an independent act by which a participant or beneficiary assigns his or her claim to the Hospital. The record contains no evidence that Psaras or Rovetto undertook such an act.

The Plan offers the certification of Kathy Pridmore, the Plan's Director of Medical Benefits, to support a finding of an assignment. Pridmore broadly declares that, in her experience, the Plan has "consistently followed the claims and claim review procedures" contained in the Summary Plan Description. The Plan argues that Pridmore's declaration constitutes evidence of "routine practice" that supports an inference of an assignment. *See* Fed. R. Evid. 406. We disagree.

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[8] The parties vigorously dispute whether the Subscriber Agreement requires the Hospital to obtain an assignment before the Plan is obligated to make payment. We express no opinion on the merits of this dispute. Nor do we express any opinion on other disputes regarding the interpretation of the Subscriber Agreement. For example, the Plan argues that there is no direct contractual relationship between itself and the Hospital. The question on appeal is whether the Hospital could have brought its claim under § 502(a). If it could not, then removal was improper, and the Plan's arguments on the merits, including its argument that no contract exists, can only be adjudicated in state, not federal, court.

Pridmore does not declare that the Plan routinely receives assignments prior to payment. In her recitation of the Plan's "standard procedure for processing claims," she does not even mention the execution of assignments by Plan participants or beneficiaries. As such, Pridmore's certification cannot establish a routine practice relevant to this appeal, let alone satisfy the Plan's burden of establishing federal subject-matter jurisdiction by a preponderance of the evidence.

Because the Plan has failed to demonstrate that the Hospital obtained an assignment from Psaras and Rovetto, we do not reach the "standing-by-assignment of claim" issue. Therefore, the Plan cannot demonstrate that the Hospital has standing to sue under § 502(a). As a result, the Hospital's state law claims could not have been brought under the scope of § 502(a) and are not completely pre-empted by ERISA. E.g., *Hobbs*, 276 F.3d at 1243; *Ward v. Alternative Health Delivery Sys., Inc.*, 261 F.3d 624, 627 (6th Cir. 2001); *Harris v. Provident Life & Accident Ins. Co.*, 26 F.3d 930, 933-34 (9th Cir. 1994).

B.

We further conclude that the Hospital's state law claims are predicated on a legal duty that is independent of ERISA. *See Davila*, slip op. at 8. The Hospital's claims, to be sure, are derived from an ERISA plan, and exist "only because" of that plan. *Id.* at 11. The crux of the parties' dispute is the meaning of Section 2.1 of the Subscriber Agreement, which governs payment for "Covered Services furnished to Eligible Persons." Were coverage and eligibility disputed in this case, interpretation of the Plan might form an "essential part" of the Hospital's claims. *Id.*

Coverage and eligibility, however, are not in dispute. Instead, the resolution of this lawsuit requires interpretation of the Subscriber Agreement, not the Plan. The Hospital's right to recovery, if it exists, depends entirely on-the operation of third-party contracts executed by the Plan that are

independent of the Plan itself. *Cf. Caterpillarinc. v. Williams*, 482 U.S. 386 (1987) (suit for breach of individual employment contract, even if defendant's action also constituted a breach of an entirely separate collective bargaining agreement, not pre-empted by § 301 of the Labor Management Relations Act).

We find instructive the Ninth Circuit's opinion in *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*, 187 F.3d 1045 (9th Cir. 1999). In that case, the court held that claims asserted by health care providers against a health care plan for breach of their provider agreements were not completely pre-empted under ERISA. *Id.* at 1051-52. The court reached this conclusion notwithstanding "the fact that these medical providers obtained assignments of benefits from beneficiaries of ERISA-covered health care plans." *Id.* at 1047, 1052.

The litigation in *Anesthesia Care* arose from a fee dispute between four health care providers and Blue Cross. *Id.* at 1048. Blue Cross had entered into "provider agreements" with physicians in which Blue Cross agreed to identify the providers in the information it distributed to beneficiaries of the plan and to direct beneficiaries to those providers. In return, the providers agreed to accept payment for services rendered to beneficiaries according to specified fee schedules. When Blue Cross attempted to change the fee schedules, the providers filed a class action in state court alleging a breach of the provider agreements. *Id.* at 1049.

The Ninth Circuit held that "the Providers' claims, which arise from the terms of their provider agreements and could not be asserted by their patient-assignors, are not claims for benefits under the terms of ERISA plans, and hence do not fall within § 502(a)(1)(B)." *Id.* at 1050. The court explained:

> *[T]he Providers are asserting contractual breaches . . . that their patient-assignors could not assert: the patients*

> *simply are not parties to the provider agreements between the Providers and Blue Cross*. The dispute here is not over the *right* to payment, which might be said to depend on the patients' assignments to the Providers, but the *amount*, or level, of payment, which depends on the terms of the provider agreements.

Id. at 1051 (first emphasis added). Because the Providers asserted "state law claims arising out of separate agreements for the provision of goods and services," the court found "no basis to conclude that the mere fact of assignment converts the Providers' claims into claims to recover benefits under the terms of an ERISA plan." *Id.* at 1052.[9]

The facts of this case are similar to *Anesthesia Care* in important respects: (1) the Hospital's claims in this case arise from the terms of a contract—the Subscriber Agreement—that is allegedly independent of the Plan; (2) the participants and beneficiaries of the Plan do not appear to be parties to the Subscriber Agreement; and (3) "[t]he dispute here is not over the *right* to payment, which might be said to depend on the

---

[9] The reasoning in Anesthesia Care was followed in Orthopaedic Surgery Associates of *San Antonio, P.A. v. Prudential Health Care Plan, Inc.*, 147 F. Supp. 2d 595 (W.D. Tex. 2001). The facts in *Orthopaedic Surgery* are nearly identical to this case. In *Orthopaedic Surgery*, health care providers entered into contracts with a healthcare plan, Prudential. Under the contracts, Prudential agreed to pay the providers for services rendered to beneficiaries of the plan. When Prudential allegedly paid the providers less than the agreed upon amount, the providers sued for breach of the physician agreements. *Orthopaedic Surgery*, 147 F. Supp. 2d at 597. The District Court in *Orthopaedic Surgery* remanded the case to state court, concluding that § 502(a) did not completely pre-empt the providers' claims. Citing *Anesthesia Care*, the court characterized the providers' claims as "claim[s] for the amount or level of payment and not the right to payment." *Id.* at 601. The court rejected Prudential's argument that, since the medical services that were allegedly unpaid were provided to participants or beneficiaries of ERISA plans, the providers' claims sought benefits payable under the terms of those plans.

patients' assignments to the [Hospital], but the *amount*, or level, of payment, which depends on the terms of the [Subscriber Agreement]." *Id.* at 1051.

C.

We have not overlooked the apparent convergence between the Hospital's breach of contract claim and a claim for benefits under § 502(a). Because the Plan is a reimbursement plan, the payments made to the Hospital *are* the benefits received by Psaras and Rovetto under the Plan. As a result, it would appear that any claims the Hospital could have obtained by assignment from Psaras and Rovetto would be for the same amount as the breach of contract claims that are the subject of this appeal. Moreover, had the Hospital successfully sued Psaras and Rovetto for the payments due, it would appear that any claims for reimbursement that Psaras and Rovetto would have against the Plan would be claims for benefits under § 502(a). Indeed, one of the principal reasons why courts have allowed participants and beneficiaries to assign their claims under § 502(a) is to avoid the necessity of providers suing patients in the first instance. *See Cagle*, 112 F.3d at 1515.

Nevertheless, the absence of an assignment is dispositive of the complete pre-emption question. Although the Hospital "may not defeat removal by omitting to plead necessary federal questions in a complaint," *Franchise Tax Bd.*, 463 U.S. at 22, it is clear that the Hospital is asserting a claim that could not be asserted under the civil enforcement provision of ERISA. It may very well be that the Hospital's breach of contract claim against the Plan will fail under state law, or that the Hospital's state law claims are pre-empted under § 514(a). These matters, however, go to the merits of the Hospital's breach of contract claim, which can only be adjudicated in state court.

IV.

Under the well-pleaded complaint rule, the Hospital's complaint does not present a federal question that would support removal. The complaint does not expressly refer to ERISA or the federal common law of ERISA, and the rights or immunities created under ERISA are not elements, let alone essential elements, of the plaintiff's claims. Moreover, the Hospital's state law breach of contract claims are not completely pre-empted by ERISA's civil enforcement provision, because the Hospital could not have brought its claims under that provision. Accordingly, removal in this case was improper, and the order of the District Court denying remand will be vacated. We will remand this case to the District Court with instructions that the District Court, in turn, remand to the Superior Court of New Jersey.

ALITO, *Circuit Judge*, concurring in the judgment.

I concur in the judgment based on the decision in *N.E. Dept't ILGWU Health & Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147 (3d Cir. 1985). Although there is now substantial contrary authority, we are bound by prior panel decisions of our Court until they are overruled.

The Court avoids the question whether an assignee can assert a claim under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), by holding that there is insufficient evidence to support a finding that there were assignments in this case. I disagree. While the summary judgment record does not contain any express assignments of the claims at issue, there is ample evidence to support a finding that the claims were assigned to the Hospital. What happened here is very common. Participants of a health care plan received treatment from a provider; the participants did not pay for those services but instead gave the provider the information needed to bill their plan; the provider then billed the plan pursuant to a contract obligating the plan to pay the provider on the assigned claims of participants; and the plan paid, albeit at a discounted rate. These facts are more than sufficient to prove that the claims were implicitly assigned to the provider. In holding that the summary judgment record is insufficient to prove assignments, the Court ignores the obvious reality of the situation.

APPENDIX D

NOT FOR PUBLICATION

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

[Sept 26, 2003]

Civil Action No. 02-5974 (DMC)
Hon. Dennis M. Cavanaugh

PASCACK VALLEY HOSPITAL, INC.,
Plaintiff(s),

vs

LOCAL 464A UFCW WELFARE REIMBURSEMENT PLAN,
Defendant(s),

OPINION AND ORDER

This matter having come before the Court on the Motion of Defendant United Food and Commercial Workers International Union Local 464A Welfare Fund ("Defendant"), for an Order granting summary judgment, and the Cross Motion of Plaintiff Pascack Valley Hospital ("Plaintiff"), to remand the matter to State Court, and the Court having heard the arguments of counsel and reviewed the pleadings and papers filed in this matter; and

Defendant believing that Plaintiff's state law claims are completely preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (ERISA), in that Plaintiff now stands in the shoes of the Plan's beneficiaries as assignee, and therefore Defendant believes the facts show it is entitled to judgment as a matter of law; and

Plaintiff believing the action is not preempted by ERISA since Plaintiff is not a participant or beneficiary under ERISA and therefore there is no federal law claim, and therefore the matter should be remanded to the state court;[1] and

This Court being in agreement with and adopts the reasoning of counsel for Defendants as stated on the record, and further rejects the arguments put forth by counsel for Plaintiff; and

This Court agrees with and adopts the analysis and holding as set forth in *Charter Fairmount Institute, Inc. v. Alta Health Strategies*, 835 F.Supp. 233; and

This Court being satisfied that the facts presented support Defendant's argument that "the doctrine of complete preemption applies only when two circumstances are present: when the enforcement provisions of a federal statute create a federal cause of action vindicating the same interest that the plaintiff's cause of action seeks to vindicate and when there is affirmative evidence of a congressional intent to permit removal despite the plaintiff's exclusive reliance on state law." *Allstate Insurance Company v. 65 Security Plan*, 879 F.2d 90, 93 (3d Cir.1989), citing *Railway Labor*, 858 F.2d at 942-943, and both prongs of the *Allstate* test having been met in this case; and

As this case falls within the "complete preemption" exception to the well pleaded complaint doctrine, removal to

---

[1] This Court is mindful of Plaintiff's reliance upon *Northeast Dept. I.L.G.W.U. Health and Welfare Fund v. Teamsters Local Union*, 229 Welfare Fund, 764 F2d 147 (3d Cir. 1985) wherein Judge Becker's footnote 6 expressed "serious doubts whether a plan beneficiary could assign her right to sue in federal court along with her substantive rights under ERISA." However, as several courts in this Circuit have pointed out, since ILGWU did not present the question of whether the beneficiary had executed an assignment, Judge Becker's comments could be considered non-binding dicta.

federal court was proper, and remand to state court would be inappropriate; and for good cause having been shown,

It is hereby ordered on this 26 day of September, 2003:

1. Defendant's Motion for Summary Judgement is granted and Plaintiff's Complaint is dismissed without prejudice;

2. Plaintiff's Cross Motion for Remand is denied; and

3. Defendant's Motion for Reasonable Attorney's Fees and Costs is denied.

/s/ DENNIS M. CAVANAUGH
Dennis M. Cavanaugh
United States District Judge

cc: All Parties
Hon. Mark Falk, U.S.M.J.

APPENDIX E

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Our File No. 28337.06-5

SUPERIOR COURT OF NEW JERSEY LAW DIVISION,
BERGEN COUNTY

[Filed Oct 23, 2002]

DOCKET NO: L8597-02

PASCACK VALLEY HOSPITAL, INC.
(Kimberly Rovetto and Betty Psoras),
Plaintiff,

vs,

LOCAL 464 UFCW WELFARE REIMBURSEMENT PLAN
Defendant.

COMPLAINT, DESIGNATION OF TRIAL COUNSEL AND CERTIFICATION

Plaintiff, PASCACK VALLEY HOSPITAL, INC., a non-profit corporation organized and existing under the laws of the State of New Jersey, with offices located at 250 Old Hook Road in the Township of Westwood, County of Bergen and State of New Jersey, by way of Complaint against defendant, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN

with an address at 245 Paterson Avenue in the Township of Little Falls, County of Passaic, and State of New Jersey, says:

FIRST COUNT

1. PASCACK VALLEY HOSPITAL, INC., was at all relevant times engaged in providing medical services to members of the public, including persons employed and/or represented by LOCAL 464 UFCW WELFARE REIMBURSEMENT PLAN.

2. PASCACK VALLEY HOSPITAL, INC. entered into a contract with MAG NET wherein PASCACK VALLEY HOSPITAL, INC. agreed to become a member of a PPO Network and to accept discounted payment for group health coverage services provided to subscribers subject to considerations detailed in the contract between PASCACK VALLEY HOSPITAL, INC. and MAG NET.

3. LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN provides group health care coverage benefits to its members and their dependents. Under a contractual relationship with MAG NET, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN accesses preferred rates and/or discounts on behalf of its members and their dependants for covered services.

4. Pursuant to said contractual relationship, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN became obligated to pay PASCACK VALLEY HOSPITAL, INC. for eligible medical services provided by PASCACK VALLEY HOSPITAL, INC. to subscribers, members and/or their dependents.

5. In order to qualify for eligibility to receive discounted rates, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN was required to comply with certain terms and conditions of PASCACK VALLEY HOSPITAL, INC.'S contract with MAG NET, requiring payment in the time period specified in said contract.

6. On information and belief, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN entered into a contract with MAG NET with like or similar terms. PASCACK VALLEY HOSPITAL, INC. is an intended Third-Party Beneficiary of that contract.

7. Services were rendered to BETTY PSORAS, a subscriber of LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN, from April 7, 1999 through April 8, 1999.

8. The total for services rendered to BETTY PSORAS was $8,703.10.

9. LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN remitted payment in the amount of $1,100,00, leaving a balance due and owing of $7,603.10.

10. LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN breached a condition precedent in that it failed to make payment within the contractually required time period.

11. As a result of said breach, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN is not eligible to pay a discounted rate for services rendered to BETTY PSORAS.

12. As a result of the foregoing failure to pay, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN has been unjustly enriched to the detriment of PASCACK VALLEY HOSPITAL, INC.

13. Demand was made upon LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN for payment of its balance due in the amount of $7,603.10; however, LOCAL464 WELFARE REIMBURSEMENT PLAN has refused to make payment.

SECOND COUNT

1. Plaintiff hereby repeats and realleges each and every paragraph contained in the First Count with the same force and effect as though set forth herein at length.

2. Services were rendered to KIMBERLY ROVETTO, a subscriber of LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN, from September 14, 1999 through September 24, 1999.

3. The total for services rendered to KIMBERLY ROVETTO was $25,938.99.

4. LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN remitted payment in the amount of $11,000.00, leaving a balance due and owing of $14,938.99.

5. LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN breached a condition precedent in that it failed to make payment within the contractually required time period.

6. As a result of said breach, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN is not eligible to pay a discounted rate for services rendered to KIMBERLY ROVETTO.

7. As a result of the foregoing failure to pay, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN has been unjustly enriched to the detriment of PASCACK VALLEY HOSPITAL, INC.

8. Demand was made upon LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN for payment of its balance due in the amount of $14,938.99; however, LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN has refused to make payment.

WHEREFORE the plaintiff, PASCACK VALLEY HOSPITAL, INC., demands judgment against LOCAL464 UFCW WELFARE REIMBURSEMENT PLAN for payment in the amount of $22,542.09, together with lawful interest and costs of suit.

/s/ CAMILLE JOSEPH KASSAR
Camille Joseph Kassar

DATED: October 18, 2002

DESIGNATION OF TRIAL COUNSEL

CAMILLE JOSEPH KASSAR is hereby designated as trial counsel for plaintiff, PASCACK VALLEY HOSPITAL, INC.

/s/ CAMILLE JOSEPH KASSAR
Camille Joseph Kassar
Attorney for Plaintiff,
Pascack Valley Hospital, Inc.

Dated: October 18, 2002

CERTIFICATION

I hereby certify that the matter in controversy is not the subject of any other action or arbitration proceeding now or contemplated, and that no other parties should be joined in this action. R. 4:5-1.

/s/ CAMILLE JOSEPH KASSAR
Camille Joseph Kassar

DATED: October 18, 2002

(2)

Supreme Court, U.S.
FILED
JUL 1 - 2005
OFFICE OF THE CLERK

No. 04-1452

IN THE

Supreme Court of the United States

LOCAL 464A UFCW WELFARE REIMBURSEMENT PLAN,

Petitioner,

v.

PASCACK VALLEY HOSPITAL, INC.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED BY THE PETITION

Do the federal courts have removal jurisdiction over a state-court lawsuit governed by federal common law, where the complaint does not identify the source of the common law right?

The Question Presented by the Petition is not at issue in this case because the claims asserted in the state court action are not governed by federal common law.

CORPORATE DISCLOSURE STATEMENT

Respondent Pascack Valley Hospital, Inc., a non-governmental corporate party, does not have a parent corporation and there is no publicly held company that owns 10% or more of its stock.

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Pascack Valley Hospital, Inc., as respondent, respectfully requests that this Court deny the petition seeking review of the judgment of the Third Circuit Court of Appeals.

STATEMENT OF THE CASE

The Petitioner, Local 464A UFCW Welfare Reimbursement Plan ("the Plan"), is an employee welfare benefit plan regulated by ERISA. (Pet. App. 6a). The Respondent, Pascack Valley Hospital, Inc. ("the Hospital"), is a medical service provider. (Pet. App. 28a). The Hospital brought an action against the Plan in state court to pursue contractual remedies and the Plan removed the case to federal court. (Pet. App. 5a).

The relationship between the Plan and the Hospital is purely contractual, and arises solely from both parties' relationship with MagNet, an independent organizer of a network of hospitals that have agreed to accept discounted payments for medical services provided to group health plan beneficiaries in return for the plans' promise to encourage beneficiaries to use those hospitals. (Pet. App. 6a, 28a-29a). The network hospitals (one of whom is Respondent) do not contract directly with the plans. (Pet. App. 6a). Instead, MagNet enters into separate contracts with individual plans, called Subscriber Agreements, and separate contracts with individual hospitals. (Pet. App. 6a-7a).

In 1999, the Hospital provided medical services to Betty Psaras and Kimberly Rovetto, two of the Plan's participants. (Pet. App. 7a, 29a-30a). The Plan submitted payment for these services to the Hospital at a discounted rate, but not until after the 30-day discount rate period established by the Subscriber Agreement had expired. (Pet. App. 7a-8a,

29a-30a). As a result, the Plan was contractually obligated to pay the Hospital the full amount for its services, rather than the discounted amount. (Pet. App. 7a-8a, 29a-30a). The Plan refused to make this additional payment (the difference between the discounted amount paid and the full amount owed). (Pet. App. 29a-30a).

On October 23, 2002, the Hospital filed suit against the Plan in the Superior Court of New Jersey, alleging only contract-based claims under state law to recover the unpaid amounts due. (Pet. App. 8a, 27a-31a). The Hospital's Complaint alleged that the Plan breached its contractual obligations to the Hospital, an intended third-party beneficiary of the Subscriber Agreement, by improperly taking a discount on the services provided without first satisfying the condition precedent of making payment within thirty days. (Pet. App. 8a, 28a-30a). The Plan removed the case to the United States District Court for the District of New Jersey, contending that the Complaint was completely preempted by ERISA. (Pet. App. 8a-9a).

On September 26, 2003, the district court denied the Hospital's motion to remand and granted summary judgment to the Plan on the grounds of complete preemption, dismissing the Complaint without prejudice. (Pet. App. 24a-26a). The Hospital filed a timely notice of appeal to the Third Circuit Court of Appeals. (Pet. App. 9a-10a).

Oral argument was heard by the Court of Appeals on June 16, 2004. On November 1, 2004, the Court of Appeals determined that: (1) under the well-pleaded complaint rule, the Hospital's Complaint did not present a federal question that would support removal, and (2) the Hospital's state law breach of contract claims were not completely preempted by

ERISA's civil enforcement provision because the Hospital could not have brought its claims under ERISA. (Pet. App. 6a). Accordingly, the Third Circuit vacated the district court's judgment and ordered the case remanded to state court for lack of federal subject matter jurisdiction.

REASONS FOR DENYING THE PETITION

I. THE THIRD CIRCUIT'S DECISION IS NOT CONTRARY TO SUPREME COURT PRECEDENT REGARDING REMOVAL JURISDICTION

The Third Circuit did not depart from this Court's precedents in deciding this case. To the contrary, the Third Circuit properly applied the Court's well-pleaded complaint rule and doctrine of complete preemption in determining that the Hospital's Complaint presented no federal question to support removal jurisdiction. Thus, there is no need for the Court to revisit this settled area of removal jurisprudence.

This Court has recently reaffirmed that the well-pleaded complaint rule is the proper tool for determining whether a case has been properly removed to federal court under 28 U.S.C. §§ 1331 and 1441. *See Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2494 (2004) (quoting *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 9-10 (1983)). In *Davila*, the Court also articulated the proper test for determining whether a state law claim "arises under" ERISA and is therefore completely preempted despite the manner in which a plaintiff pleads its claims. *See id.* at 2496. The Third Circuit's decision fully comports with *Davila* and other decisions of this Court.

This Court has also held that the type of the relief that the Hospital seeks – purely legal relief as defined by *Great-West Life & Annuity Insurance Company v. Knudson*, 534 U.S. 204 (2002) – is not authorized by ERISA and therefore cannot be rooted in the "federal common law" of ERISA. Therefore, as a matter of law, the Third Circuit was correct in remanding this case to state court.

A. The Third Circuit Correctly Applied This Court's Well-Settled Jurisprudence Regarding The Well-Pleaded Complaint Rule

Contrary to the Plan's assertion, there is nothing "unsettled" about "the state of 'arising under' jurisdiction" regarding removal. As this Court recently reaffirmed, determining whether a claim "arises under" federal law for purposes of removal jurisdiction under 28 U.S.C. § 1441(b) "turns on the 'well-pleaded complaint' rule." *Davila*, 124 S. Ct. at 2494 (quoting *Franchise Tax*, 463 U.S. at 9-10). Under this rule, courts are to examine "the 'well pleaded' allegations of the complaint and ignore potential defenses [including the pre-emptive effect of a federal statute]," because "'a suit arises under the Constitution and laws of the United States only when the plaintiff's statement of his own cause of action shows that it is based upon those laws or that Constitution.'" *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 6 (2003) (quoting *Louisville & Nashville R.R. Co. v. Mottley*, 211 U.S. 149, 152 (1908)). Pursuant to this "century-old jurisdictional framework governing removal of federal question cases," the plaintiff remains the "master of [its] claim," and may "avoid federal jurisdiction by exclusive reliance on state law" in drafting the complaint, even where (unlike here) a federal claim is also available. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987); *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392, 395 (1987).

Indeed, this Court has repeatedly held that under the well-pleaded complaint rule, the plaintiff's choice of a state court forum should not be disturbed if he chooses to proceed solely under state law. *Id.* at 392, 399; *Merrell Dow Pharmaceuticals, Inc. v. Thompson*, 478 U.S. 804, 809 n.6 (1986) ("Jurisdiction may not be sustained on a theory that the plaintiff has not advanced"); *Great Northern Ry. Co. v. Alexander*, 246 U.S. 276, 282 (1918) ("the plaintiff may by the allegations of his complaint determine the status with respect to removability of a case"); *The Fair v. Kohler Die & Specialty Co.*, 228 U.S. 22, 25 (1913) ("Of course, the party who brings a suit is master to decide what law he will rely upon, and therefore does determine whether he will bring a 'suit arising under' the . . . law of the United States"). In fact, the Plan acknowledges as much in the Petition. (Pet. at 7). Accordingly, a case generally will not be removable if the complaint does not "affirmatively allege" a federal claim or if federal law is not an "essential element" of the plaintiff's cause of action. *Beneficial Nat'l Bank*, 539 U.S. at 6; *Franchise Tax*, 463 U.S. at 11 (citing *Gully v. First Nat'l Bank*, 299 U.S. 109, 112 (1936)). *See also Pinney v. Nokia, Inc.*, 402 F.3d 430, 442 (4th Cir. 2005) ("[i]f a plaintiff can establish, without the resolution of an issue of federal law, all of the essential elements of his state law claim, then the claim does not necessarily depend on a question of federal law" and removal is improper) (citing *Franchise Tax*, 463 U.S. at 13-14).

The Third Circuit applied this rule to determine that the Hospital's Complaint for breach of contract, which alleges no federal claims on its face, does not depend upon federal law. This is because, as the Third Circuit properly held, neither the rights or immunities created under ERISA (which the Hospital lacks standing to invoke), nor the federal

common law of ERISA, provides *any* element, much less an essential element, of the Hospital's claims. (Pet. App. 11a, 12a, 14a-15a). Thus, the Hospital's claims for the Plan's breach of the Subscriber Agreement must be premised exclusively upon New Jersey common law. (Pet. App. 11a-12a, 18a-22a). The Plan's disagreement with this conclusion does not warrant a grant of certiorari.

Nevertheless, the Plan insists that the Hospital's claims are necessarily based on the federal common law of ERISA, and that therefore, the Third Circuit's conclusion to the contrary must be reviewed. However, this Court has previously instructed that "[t]he authority of courts to develop a 'federal common law' under ERISA is not the authority to revise the text of the statute." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 259 (1993); *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 447 (1999) (warning that ERISA "should not be supplemented by extratextual remedies" such as those formed by common law, which "must give way [when] inconsistent with 'the language of the statute, its structure, or its purposes'") (citations omitted). Thus, any federal common law of ERISA must be premised upon an express provision of ERISA. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (citations omitted) (reaffirming that Congress did not authorize the courts to create remedies that ERISA does not expressly incorporate or specifically authorize) (citations omitted); *Community Health Plan v. Mosser*, 347 F.3d 619, 624 (6th Cir. 2003) (holding that after *Knudson*, "federal question jurisdiction does not exist under 28 U.S.C. § 1331 if ERISA does not authorize the suit").

Since there is no provision of ERISA under which the Hospital's claims may arise, those claims may not arise under

ERISA's federal common law. *Knudson*, 534 U.S. at 209, 218, 220-21; *Mertens*, 508 U.S. at 259. First, under the terms of the statute, only the Secretary of Labor and plan participants, beneficiaries or fiduciaries are empowered to bring suit under ERISA. 29 U.S.C. § 1132(a) (West 2005). Claims by other entities, such as the Hospital, cannot "arise under" ERISA or its common law and therefore cannot be filed in federal court. *See Franchise Tax*, 463 U.S. at 27 (since ERISA "carefully enumerates" the parties entitled to file civil actions, a suit for relief by some other party does not "arise under" its provisions); *Bauhaus USA, Inc. v. Copeland*, 292 F.3d 439, 442 n.6 (5th Cir. 2002) (where ERISA does not authorize the suit, "there is no independent ground for federal question jurisdiction under § 1331").

Second, ERISA does not authorize the type of strictly legal relief that the Hospital seeks. *Knudson*, 534 U.S. at 221. In *Knudson*, this Court explained that ERISA does not authorize actions for money damages, regardless of whether they are couched in terms of an equitable remedy such as restitution or unjust enrichment. *Id.* at 209-15, 221. Instead, whether the remedy sought is legal or equitable depends upon the basis for the plaintiff's claim and the nature of the underlying remedy. *Id.* at 213. Thus, the Court explained, a plaintiff seeking to impose personal liability "for a contractual obligation to pay money – relief that was not typically available in equity," is seeking money damages, "'the classic form of *legal* relief.'" *Id.* at 210 (quoting *Mertens*, 508 U.S. at 255) (emphasis in original). As a matter of law, such claims cannot arise under ERISA. *Id.* at 218, 221. Therefore, there can be no federal subject matter jurisdiction over them. *Qualchoice, Inc. v. Rowland*, 367 F.3d 638, 642 (6th Cir. 2004), *cert. denied*, 125 S. Ct. 1639 (2005). Indeed, Justice Ginsberg expressly recognized this to be the

case in *Knudson*: "[a]fter today, [parties] unable to fit their suits within the confines the Court's opinion constructs *are barred from a federal forum*" and may seek relief only in state court. *Knudson*, 534 U.S. at 227 (Ginsberg, J., dissenting) (emphasis added).

The Hospital's Complaint asserts only one type of claim for relief: money due and owing under a contract. Thus, the Hospital's suit is "'quintessentially an action at law,'" *id.* at 210 (quoting *Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells*, 213 F.3d 398, 401 (7th Cir. 2000)), and cannot arise under ERISA or its federal common law. *Id.* at 218, 221; *Franchise Tax*, 463 U.S. at 27.[1]

Additionally, the federal common law sanctioned by Congress under ERISA was never intended to apply to

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[1] The Plan attempts to dismiss the fatal effect of *Knudson* on its federal jurisdiction claims by a lone citation to a district court case, *Empire Kosher Poultry, Inc. v. UFCW Health & Welfare Fund*, 285 F. Supp.2d 573 (M.D. Pa. 2003). In *Empire*, the district court erroneously concluded that *Knudson* did not abolish extratextual federal common law remedies because *Knudson* cited to the 1985 case of *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), in instructing courts not to "tamper with ERISA's enforcement scheme . . . by extending remedies not specifically authorized by its text." The *Empire* court reasoned that the Third Circuit must have been aware of *Russell* when it created a federal common law remedy in *Plucinski v. IAM Nat'l Pension Fund*, 875 F.2d 1052 (3d Cir. 1989), and that therefore, *Knudson*'s reaffirmation of *Russell* in 2002 could have no effect on Third Circuit precedent under *Plucinski*. *Empire*, *supra* at 581 n.9. This analysis by the district court cannot nullify *Knudson*'s clarification of the availability of federal common law ERISA remedies. Further, unlike here, the plaintiff in *Empire* expressly invoked federal jurisdiction in its complaint, thereby giving the court subject matter jurisdiction to consider the claim.

ordinary contract disputes between a welfare plan and a non-ERISA entity such as the Hospital. *Bollman Hat Co. v. Root*, 112 F.3d 113, 115 (3d Cir.), *cert. denied*, 522 U.S. 952 (1997) ("[a] case arises under federal common law if the issue presented is one 'of central concern' to ERISA"). Rather, Congress authorized the development of such common law only to deal with issues involving the rights and obligations of participants, beneficiaries and fiduciaries under private welfare and pension plans. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110, 113 (1989); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987); 29 U.S.C. § 1001 (West 2005) (declaring Congressional purpose of ERISA to be the protection of plan participants and beneficiaries and the establishment of plan fiduciary responsibilities).

This is demonstrated by the Third Circuit cases relied upon by the Plan, which all pre-date *Knudson* and involve either: (1) an interpretation of plan terms regarding coverage for beneficiaries or participants, or (2) equitable unjust enrichment or restitution claims in the form of a plan's retention of overpaid fund contributions or its subrogation rights against a participant or beneficiary.[2] These cases do not apply to the Hospital's claims, which seek payment of a contractual obligation to pay for services rendered by a third party. (Pet. App. 8a, 28a-30a). *See also Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988) (instructing that "run-of-the-mill" state-law tort and breach

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[2] *See Bollman Hat Co.*, 112 F.3d at 114-15, 116-17; *Airco Indus. Gases, Inc. v. Teamsters Health & Welfare Pension Fund*, 850 F.2d 1028, 1030-31 (3d Cir. 1988); *Northeast Dep't ILGWU Health & Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147, 150 (3d Cir. 1985); *McGurl v. Trucking Employees of North Jersey Welfare Fund, Inc.*, 124 F.3d 471, 473 (3d Cir. 1997); *Plucinski v. IAM Nat'l Pension Fund*, 875 F.2d 1052, 1053 (3d Cir. 1989).

of contract suits against ERISA plans, regardless of whether such suits will affect or result in money judgments against plan assets, are not pre-empted by ERISA).

These cases also do not support the Plan's claim for removal jurisdiction because, unlike the Hospital, the plaintiffs therein invoked federal law, subjecting them to federal jurisdiction under the well-pleaded complaint rule. *See, e.g., Bollman*, 112 F.3d at 115; *Airco*, 850 F.2d at 1031; *ILGWU*, 764 F.2d at 150; (Pet. App. 12a). The Plan's reliance on *City of Chicago v. International College of Surgeons*, 522 U.S. 156 (1997), *Wisconsin Dep't of Corrections v. Schacht*, 524 U.S. 381 (1998) and *Schlesinger v. Councilman*, 420 U.S. 738 (1975), fails for this reason as well.

In *City of Chicago*, the plaintiff alleged violations of federal law (the Fifth and Fourteenth Amendments) on the face of its complaint. *City of Chicago*, 522 U.S. at 160. Likewise, in *Schacht*, the plaintiff's complaint alleged violations of the Fourteenth Amendment and 42 U.S.C. § 1983, while *Schlesinger* involved a jurisdictionally uncontested constitutional conflict between the "military justice system established by Congress and the powers and responsibilities of Article III courts." *Schacht*, 524 U.S. at 383-84; *Schlesinger*, 420 U.S. at 740. Thus, unlike this case, federal question jurisdiction was proper in those cases because the federal claims were either specifically plead by the plaintiff or were apparent on the face of the complaint. *City of Chicago*, *supra* at 163-64; *Schacht*, *supra* at 383-84; *Schlesinger*, *supra* at 740, 744-45 & n.9.[3]

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[3] The Plan has notified the Hospital that it also intends to rely upon this Court's recent decision in *Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing*, 125 S.Ct. 2363, 2005 (Cont'd)

B. The Third Circuit Correctly Applied This Court's Decisions Regarding The Doctrine Of Complete Preemption

The Plan contends that the logical extension of the Third Circuit's construction of the well-pleaded complaint rule is that removal will be "impossible whenever the plaintiff does not expressly acknowledge the federal nature of its claim." (Pet. at 7). However, this "logical conclusion" ignores the fact that the Third Circuit looked beyond the express allegations of the Complaint to determine if federal common law provided an essential element of the Hospital's claims under the rule. (Pet. App. 11a-12a). Such a conclusion also ignores Supreme Court precedent regarding the doctrine of complete preemption, which the Third Circuit also properly applied. (Pet. App. 13a-22a).

(Cont'd)
WL 1383604 (2005) in support of its Petition. However, in *Grable*, the Court decided that federal subject matter jurisdiction existed because of the "dispositive and contested federal issue at the heart of [the plaintiff's] state-law title claim" (raised by the face of the complaint): whether the Internal Revenue Service had given plaintiff proper notice of seizure under 26 U.S.C. § 6335. *Id.* at *5, 7. Thus, the issue of whether the plaintiff had been given notice within the meaning of the federal statute was "an *essential element* of its quiet title claim." *Id.* at 5 (emphasis added). Consequently, *Grable* is consistent with this Court's well-pleaded complaint jurisprudence, and *supports* the Third Circuit's analysis. *See Franchise Tax*, 463 U.S. at 10-11 (to support removal, federal law "must be an element, *and an essential one*, of the plaintiff's cause of action") (emphasis added); (Pet. App. 12a) (the federal common law of ERISA *does not provide an element – essential or otherwise* – of [the Hospital's] claim) (emphasis added).

Complete preemption is an exception to the well-pleaded complaint rule, which states that if a federal statute "'wholly displaces the state-law cause of action through complete pre-emption,' the state-law claim can be removed." *Davila*, 124 S. Ct. at 2494-95 (quoting *Beneficial Nat'l Bank*, 539 U.S. at 8). This is because any state law claim that comes within the scope of a completely preemptive federal statute, "even if pleaded in terms of state law, is in reality based on federal law." *Beneficial Nat'l Bank*, *supra* at 8. ERISA's civil enforcement provision, § 502(a), codified at 29 U.S.C. § 1132(a), is such a statute. *Davila*, *supra* at 2495-96. Thus, *Davila* answers the Question Presented by the Plan: if a state-court lawsuit is governed by federal common law, complete preemption will support removal regardless of whether the complaint identifies the source of the federal common law right. *Id.* at 2494-95; *see also Metropolitan Life*, 481 U.S. at 66-67 (holding that although plaintiff's suit purported to raise only state law claims, it was completely preempted by § 502 and was therefore removable under 28 U.S.C. §§ 1331 and 1441(b)).[4] Last year, this Court revisited this question in the context of ERISA claims.

In *Davila*, this Court provided the two-pronged test for determining whether a state law based complaint that does not refer to federal law may be removed under ERISA. The

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[4] Only complete preemption under §502(a) is a basis for removal. *Metropolitan Life*, 481 U.S. at 62-66. Conflict preemption under §514 is a defense which cannot overcome the plaintiff's choice of law and forum under the well-pleaded complaint rule. *Id.* at 64 (citing *Franchise Tax*, 463 U.S. at 25-27); *Caterpillar Inc.*, 482 U.S. at 393 ("it is now settled law that a case may *not* be removed to federal court on the basis of a federal defense, including the defense of preemption") (emphasis in original) (citing *Franchise Tax*, 463 U.S. at 12).

Court analyzed removal under § 1132(a)(1)(B), which is the precise statutory provision under which the Plan claims complete preemption. *Davila*, 124 S. Ct. at 2496; (Pet. App. 14a & 14a n.5). Under *Davila*, such a complaint is completely preempted and is therefore removable if: (1) the plaintiff could have brought its claim under § 502(a), *and* (2) no other independent legal duty implicating the defendant's actions supports the plaintiff's claim. *Davila*, *supra* at 2496.

The Third Circuit carefully analyzed the Plan's contentions under this test. (Pet. App. 13a-22a). As to the first prong, the court properly concluded that the Hospital was not one of the parties entitled to bring suit under § 502(a). Therefore, it had no standing to bring an ERISA claim in federal court. (Pet. App. 14a-18a (citing *Franchise Tax*, 463 U.S. at 27)); *see also Dallas County Hosp. Dist. v. Associates' Health & Welfare Plan*, 293 F.3d 292, 285 (5th Cir. 2002) (absent a valid assignment allowing classification as a participant or beneficiary, "a health care provider has no independent right of standing to seek redress under ERISA").[5] Indeed, as set forth above, *Franchise Tax, Mertens*, and *Knudson* made this clear before *Davila* was decided. As to the second prong, the court correctly determined that the Hospital's claims are predicated not on the Plan, but on the independent legal duty created by the third-party contract (the Subscriber Agreement) executed by the Plan. (Pet. App. 18a-21a). As a result, the Hospital's claims are not completely preempted under ERISA and could not have been brought in federal court. (Pet. App. 18a-21a).

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[5] The Plan presented no evidence that the Hospital obtained an assignment of rights from Psaras or Rovetto. (Pet. App. 16a-18a).

II. THE THIRD CIRCUIT'S DECISION DOES NOT CREATE A CONFLICT AMONG THE CIRCUITS

The Plan incorrectly asserts that certiorari is warranted because the Third Circuit's decision conflicts with the decisions of other Courts of Appeal concerning the well-pleaded complaint rule. Contrary to this assertion, the Third Circuit applied this rule no differently than its sister Circuits.

In the Fourth, Second, Ninth and Eleventh Circuit decisions cited by the Plan, the court applied the well-pleaded complaint rule to determine whether the plaintiff's state law claims involved inexplicitly plead or unplead essential elements of federal law that would support federal jurisdiction (i.e., whether the claims "necessarily depended" on federal law). *See Battle v. Seibels Bruce Ins. Co.*, 288 F.3d 596, 606-08 (4th Cir. 2002) (federal jurisdiction based on fact that only federal common and regulatory law governed interpretation of insurance policies sued upon, which were issued under National Flood Insurance Program); *Marcus v. AT&T Corp.*, 138 F.3d 46, 52-56 (2d Cir. 1998) (federal jurisdiction based on fact that both the parties' legal relationship and the plaintiff's cause of action were premised exclusively upon federal tariffs, which "conclusively and exclusively" determined the parties' rights and liabilities); *California ex rel. Lockyer v. Dynegy, Inc.*, 375 F.3d 831, 838-41 & n.6 (9th Cir. 2003), *cert. denied*, 125 S. Ct. 1836 (2005) (removal proper because the state lawsuit "turn[ed], entirely, on defendant's compliance with a federal regulation"; plaintiff's complaint repeatedly cited to federal tariff allegedly violated by defendant); *Hill v. Bellsouth Telecomm., Inc.*, 364 F.3d 1308, 1314-17 (11th Cir. 2004) (removal jurisdiction based on substantial question of federal law

raised by plaintiff's attack on reasonableness of FCC-approved tariffs); *D'Alessio v. New York Stock Exch., Inc.*, 258 F.3d 93, 101-03 (2d Cir.), *cert. denied*, 534 U.S. 1066 (2001) (federal jurisdiction existed because complaint allegations established that "central premise" of suit was alleged violations of federal securities laws); *Sparta Surgical Corp. v. National Ass'n of Sec. Dealers*, 159 F.3d 1209, 1211-12 (9th Cir. 1998) (removal justified because complaint alleged violations of federal security exchange rules, thereby conferring exclusive jurisdiction on federal courts under Security Exchange Act of 1934).

The Third Circuit applied the same analysis to the Hospital's claims. (Pet. App.11a-12a.) The fact that the Third Circuit did not find that federal statutory or common law were essential elements of the Hospital's claims does not create a conflict with these decisions, particularly since none of them involved alleged ERISA related-claims and the jurisdictional issues they present under § 502(a). In fact, the federal courts which have faced the precise issue presented by this case have determined, as the Third Circuit did, that federal question jurisdiction did not exist.

For example, in *Blue Cross v. Anesthesia Care Associates Medical Group, Inc.*, 187 F.3d 1045 (9th Cir. 1999), the Ninth Circuit Court of Appeals was presented with claims by medical providers against a health care plan for breach of contract. The case involved alleged breaches of Blue Cross' "provider agreements" with the doctors. Under the agreements, Blue Cross had agreed to direct plan subscribers to the doctors for medical care and to pay the doctors according to specified fee schedules. *Id.* at 1048. When Blue Cross attempted to change the fee schedules, the doctors filed

a class action lawsuit in state court for breach of the agreements, which Blue Cross then removed to federal court. *Id.* at 1049.

In rejecting Blue Cross' claims of removal jurisdiction based upon ERISA preemption, the Ninth Circuit held that because the doctors' claims were premised solely upon the terms of the provider agreement, rather than the plan, there was no federal question jurisdiction under ERISA. *Id.* at 1050-52. This is the same result reached by the Third Circuit. (Pet. App. 13a-22a). *See also Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752, 754-56 (10th Cir. 1991) (holding that health care provider's state law promissory estoppel claim was not sufficiently connected with or related to ERISA plan to justify preemption, noting that "[a]n action brought by a health care provider to recover a promised payment from an insurance carrier is distinct from an action brought by a plan participant against the insurer seeking recovery of benefits due under the terms of the insurance plan"); *In Home Health, Inc. v. The Prudential Ins. Co.*, 101 F.3d 600, 604-05, 607 (8th Cir. 1997) (remanding health care provider's removed negligent misrepresentation claim against administrator of employee benefit plan for lack of ERISA preemption; provider was suing for damages on claims that were non-derivative and independent of any claims for plan benefits).[6]

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[6] Numerous district courts have reached this same result based upon similar facts. *See, e.g., Johns Hopkins Hosp. v. Carefirst of Maryland, Inc.*, 327 F. Supp.2d 577, 579-81 (D. Md. 2004); *Children's Hosp. Corp. v. Kindercare Learning Ctrs., Inc.*, 360 F.Supp.2d 202, 204-07 (D. Mass. 2005); *Baylor Univ. Med. Ctr. v. Arkansas Blue Cross Blue Shield*, 331 F.Supp.2d 502, 505-10 (N.D. Tex. 2004); *Orthopaedic Surgery Assocs. of San Antonio, P.A. v. Prudential Health Care Plan, Inc.*, 147 F.Supp.2d 595, 597-603 (W.D. Tex. 2001).

CONCLUSION

For all of the foregoing reasons, the Petition for a Writ of Certiorari should be denied.

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IN THE

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LOCAL 464A UFCW WELFARE REIMBURSEMENT PLAN,
Petitioner,

v.

PASCACK VALLEY HOSPITAL, INC.,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITIONER'S REPLY MEMORANDUM IN SUPPORT OF PETITION FOR CERTIORARI

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Respondent Pascack Valley Hospital makes two arguments in defense of the Third Circuit's remand. First, it argues that, under the "well-pleaded complaint" rule, its decision to file its common-law action in state court determines the state-law character of its claim. This argument was rejected last month in *Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing*, 545 U.S. ___, 125 S.Ct. 2363 (2005).

Second, the Hospital attacks the Third Circuit's recognition of a federal common-law right of action under ERISA. It argues, contrary to the Third Circuit, that there is no longer such a federal common-law right at all. This is an interesting issue, but the Court need not address it in the absence of a

cross-petition for certiorari. The question presented here concerns removal principles under 28 U.S.C. §1331, not the merits of the underlying ERISA case. To permit a clear resolution of the question presented, this Court may assume the correctness of the Third Circuit's view of ERISA common law without deciding it.

1. *Grable & Sons Metal Products* rejected the formalistic version of the "well-pleaded complaint" rule the Hospital urges here.

The Hospital argues that "the plaintiff's choice of a state court forum should not be disturbed if he chooses to proceed solely under state law," *citing Merrell Dow Pharmaceuticals, Inc. v. Thompson*, 478 U.S. 804, 809 (1986). This argument echoes Justice Holmes' dissent in *Smith v. Kansas City Title & Trust Co.*, 255 U.S. 180, 214 (1921).

The Court rejected this reading of *Merrell Dow* last month in *Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing*, 545 U.S. ___, 125 S.Ct. 2363 (2005). Under *Grable*, the fact that the plaintiff has presented a federal claim "in state-law raiment" does not preclude removal. 125 S.Ct. at 2368. The federal courts have authority to decide for themselves the federal character of a claim, even over the plaintiff's objection. 125 S.Ct. at 2368-70.[1] After *Grable*, courts may assess removal simply by balancing the federal interest in adjudicating the case against the structural consequences of removal for the allocation of work between state and federal courts. *Grable*, 125 S.Ct. at 2371.

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[1] *Grable* also defeats the Hospital's attempt to confine removal to the "complete preemption" exception. The federal tax laws at issue in *Grable* are not within any recognized "complete preemption" exception. As we explain in our Petition, p.5 n.1, the petition seeks certiorari for the Third Circuit's rejection of "arising under" jurisdiction, not its discussion of complete preemption later in its opinion.

This case permits the Court to develop its reasoning in *Grable* further. At a minimum, this Court should vacate and remand the case to the Third Circuit for further consideration in light of *Grable*.

2. The Court need not decide the merits of whether ERISA provides a federal common-law right of action.

The Hospital's only other defense of the Third Circuit's remand is to attack the Third Circuit's underlying recognition of a federal common law under ERISA. Even though the Third Circuit reaffirmed its recognition of an ERISA common law governing employee benefit plans, Pet.App. 12a-13a, the Hospital now argues that Third Circuit law is obsolete in light of *Great-West Life Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

This is the only basis on which the Hospital distinguishes the conflicting Circuit cases we cite in the Petition at 13-15. The Hospital simply argues on the merits that in all the other cases, there was a genuine federal source of law for the removed state-court claims, whereas here (contrary to the Third Circuit's pre-*Knudson* decisions) there is not.

The Court need not decide this issue. The Hospital has not filed a cross-petition for certiorari over the Third Circuit's continued recognition of a federal common-law right under ERISA. Unlike issues of standing that bear on Article III jurisdiction, the question whether ERISA creates a statutory right of action is a matter of statutory interpretation, which the Court may assume without deciding. *Steel Co. v. Citizens for a Better Environment*, 523 U.S. 83, 89 (1998).

For present purposes, the Court may assume without deciding that the Third Circuit's construction of ERISA is correct, and decide the removal question presented on that basis. *Northwest Airlines, Inc. v. County of Kent*, 510 U.S. 355, 365 (1994) ("The question whether a federal statute creates a

claim for relief is not jurisdictional. [cit.om.] Accordingly, we shall assume, solely for purposes of this case, that the alleged AHTA private right of action exists."); *Air Courier Conference of America v. American Postal Workers Union*, 498 U.S. 517, 523 n.3 (1991) *citing Burks v. Lasker*, 441 U.S. 471, 476 n.5 (1979) ("Whether a cause of action exists is not a question of jurisdiction, and may be assumed without being decided.").

Once the Court corrects the Third Circuit's error in removal jurisdiction, it may remand the statutory issue to the Third Circuit for further consideration.

CONCLUSION

The Court should grant the petition for certiorari.

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